OVERALL POLICY FORMULATION PROCESSES AND IMPLEMENTATION METHOD WITH A SPECIAL FOCUS ON HUMAN RESOURCES FOR HEALTH: A LEARNING EXPERIENCE OF INDONESIA CASE

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ABSTRAK

Penelitian ini merupakan studi eksplorasi yang bertujuan untuk mengidentifikasi mekanisme proses pengembangan dan implementasi kebijaksanaan bidang kesehatan khususnya dititik beratkan pada bidang pengembangan tenaga kesehatan. Data dan informasi dikumpulkan dengan melakukan diskusi intensif dengan para pengambil kebijakan di lingkungan Departemen Kesehatan yang ada kaitannya dengan mekanisme pengembangan ketenagaan bidang kesehatan tersebut. Subjek penelitian adalah para Eselon I, II dan III di lingkungan Sekretariat Jendral Depkes, khususnya Biro Perencanaan, Biro Kepegawaian, Pusat Pendidikan Tenaga Kesehatan (Pusdiknakes), dan Pusat Pendidikan dan Latihan Pegawai (Pusdiklat), serta di lingkungan Inspektorat Jendral, khususnya Inspektorat Kepegawaian.

Hasil studi ini menunjukkan bahwa perencanaan tenaga kesehatan yang dilaksanakan secara komprehensif yang terakhir dilaksanakan pada awal dekade tahun 1980-an, yang kemudian dilakukan perhitungan kebutuhan tenaga berdasarkan 'Indicator Staff Need' (ISN) pada tahun 1985. Modifikasi metoda ini telah dilakukan beberapa kali, dan pada tahun 1991 telah diuji cobakan di 5 provinsi (Nusa Tenggara Barat, Kalimantan Timur, Jawa Timur, Sumatra Barat, dan Sulawesi Selatan). Namun demikian untuk penerapannya masih dijumpai berbagai kendala. Pada Health Project V (HP-V) telah pula dilakukan 'Professional Health Manpower Development' di mana provinsi diberi kewenangan untuk melakukan produksi dan penempatan tenaga kesehatan, serta pemberian promosi dan bentuk 'insentif' yang lain (reward system) tidak secara otomatis diberikan, namun didasarkan pada kinerja dari masing-masing personel. Seperti juga pada perencanaan tenaga yang didasarkan pada ISN, pada penerapan proyek HP-V ini juga ditemui kendala terutama dalam merealisasi bentuk insentif yang telah dijanjikan. Upaya mereview kebijaksanaan sumberdaya manusia di bidang kesehatan secara nasional dan komprehensif memang belum dilakukan namun beberapa langkah dalam mengantisipasi perubahan-perubahan situasi telah dilakukan. Sebagai contoh kebijakan 'Zero personnel growth' yang akhirnya menghasilkan kebijakan baru berupa Program Dokter dan Bidan PTT.

Proses dalam kebijakan pengembangan tenaga kesehatan paling tidak melibatkan 11 institusi di Departemen Kesehatan yaitu: 1. Biro Perencanaan, 2. Biro Kepegawaian, 3. Pusdiknakes, 4. Pusdiklat, 5-9. Bagian Kepegawaian pada masing-masing echelon I, 10. Pusdatin, dan 11. Inspektorat Kepegawaian. Selama ini masing-masing instansi tersebut membuat kebijakan yang

menyangkut aspek kepegawaian dilingkungan masing-masing, yang kemudian untuk penyelarasan kebutuhan anggaran dikoordinasikan oleh Biro Perencanaan. Dengan demikian Biro Perencanaan tidak membuat kebijakan ketenagaan untuk seluruh Departemen, akan tetapi hanya sebatas koordinasi pada aspek pembiayaan.

Dari dokumen Pelita VII serta diskusi dengan para pejabat yang berkaitan dengan pengambilan kebijaksanaan di bidang ketenagaan, dapat ditarik kesimpulan bahwa prioritas pengembangan sumberdaya manusia di bidang kesehatan adalah: 1. Pemerataan distribusi tenaga, 2. Produksi tenaga dengan kemampuan tinggi, 3. Efisiensi dan efektivas pemanfaatan tenaga, 4. Pengembangan kemampuan teknis, manajerial dan mental tenaga, dan 5. Pengembangan standar kompetensi, prosedur dan perundang-undangan. Di samping itu dari kajian ini telah pula diidentifikasi beberapa langkah dalam rangka reformasi di bidang ketenagaan antara lain: 1. Desentralisasi dalam penempatan dan perputaran tenaga, 2. Desentralisasi dalam pelaksanaan pelatihan tenaga, 3. Rotasi tenaga khususnya eselon II dan III di tingkat nasional dan lokal, 4. Pelatihan tenaga baik di dalam maupun di luar negeri, 5. Percepatan pemenuhan kebutuhan tenaga spesialis untuk RSU Kabupaten/Kodya, dan 6. Pemilihan direktur RS berdasar 'merit system'.

Key words: *Policy; Human Resources for Health; Indonesia experience*

INTRODUCTION

Background

The 1988 Basic Guidelines of State Policy (GBHN) states that the major goal of the Long Term Development in Indonesia is to harness the basic strength of the Indonesian nation for achieving community welfare based on the Indonesian ideology of "Pancasila". The 1988 "GBHN", notes the principal target of the Second Long Term Development Plan (PJPT I) is the achievement and advancement of the individual and community in Indonesia in a situation characterized by peace, physical and spiritual welfare; in the community, nation and country, a way of life based on Pancasila in the situation of harmony and perpetual relationship within human beings, between human beings and their environment, and between human beings and God. This principal target of the "PJPT II", has been further operationalized in the 1993 "GBHN", which emphasized development of "PJPT II"is still to focus on the economic sector. However in line with economic sector, the quality improvement of human resources should also be prioritized. Hence, development in Indonesia should be used for improving the quality of community life. This policy has also been strengthening in the 1998 "GBHN" which has been approved in recently (before reform movement in May 1998).

One of the most important factors in achieving a better quality of community

life is an improvement in health status. As stated in the 1960 National Health Act (UU Pokok Kesehatan 1960), health is one aspect of the quality of life which is influenced by and influences to other aspects of human existence including food, clothing, housing, culture etc. Indonesia is actively engaged in efforts to optimize the health status of its citizens. Health development activities are directed towards promoting equity and improving the quality of health services, particularly for the rural population, low income citizens in urban areas, persons living in isolated and border areas, new settlements and transmigration areas. Underlying the nation-wide effort to improve health services, are attempts to enhance the level of community participation.Health development has been carried out as part of the broad national development effort based on the "GBHN". All health development activities are directed towards increasing health status which contributes to a higher quality of productive life, socially and economically (the new Health Law No. 23, 1992 or "UU-Kesehatan No. 23, 1992"). The improvement in GNP, per capita income, education, etc. has a positive affect on health status. Hence, health services development activities should be implemented equally through out Indonesia, hand in hand with the development of other sectors as a part of the national development. This principle of health development is in line with the basic philosophy of national development which is to carry out the development of the Indonesian people in their entirely and the development of the entire Indonesian society.The National Development Policies of all sector have been integrated in the "GBHN" beginning with the First Five Year Development Plan (PELITA I). The "GBHN" provides the basic principles to guide development in Indonesia (including the health sector) for each five year planning period.

Due to the complexity of health problems in Indonesia, a National Health System (SKN), has been developed. "SKN" is a system which reflects the efforts of Indonesians to improve their capability for achieving optimal health status as one realization of community welfare as stated in the preamble to the 1945 Indonesian Constitution. The "SKN" establishes a basic framework for general health development activities on a nation-wide basis. The "SKN" also provides objectives and the basic guidance to enable health providers to carried out general and long term health development. Within the "SKN" there is a Long Term Development Plan (RPJPK), which covers health plans for the period of 1980 to 2000. The "RPJPK" is operationalized through the Long Term Basic Program of Health Development Plan (RP3JPK). The "RP3JPK" is used by the Government of Indonesia to guide national health development and implementation of health services through the end of the Sixth Five Year Development Plan (PELITA VI),

1998.With five basic policies to guide health development (the "UU-Kesehatan No. 23, 1992", the "GBHN", the "SKN", the "RPJPK" and the "RP3JPK"), Indonesia has established a basic framework to manage health development efforts including health services research.

In planning development, for the health sector and human resources particularly their links and interactions have been facing many problems and constraint, and it can still be improved. An assessment and a review of the past programs, the results achieved and problems encountered, the strengths and weaknesses of each period of "PELITA" should be carefully carried out. The results of this assessment and review can be used in conjunction with the work of Bureau of Planning, MOH in providing inputs in the development of the next health and human resources health planning. This report is requested by WHO Head Quarter on the individual assignment based on WHO letter dated on 6 July 1998, No. M12/370/21.

Objective

The study explores and assesses the mechanism of planning development in health sector, especially relatad to human resource for health planning and development; links and interactions among stakeholders.

METHOD AND MATERIALS

The type of study was an exploration study. Data and information were collected by discussion –during 1998/ 1999 fiscal year– with related program managers (stakeholders) within Ministry of Health, such as Secretary General, Bureau of Planning, Bureau of Personnel, Center for Education and Training of Human Resource for Health, Center for National Education for Human Resource for Health, Inspector General, and Inspector for Personnel. Subjects of the study were echelon I, II and III of those main institutions. Additional information was collected by reviewing some report –published and unpublished- from those stakeholders. Descriptive and qualitative data analysis was applied due to the most of the callected data were qualitative data.

HEALTH AND HUMAN RESOURCE POLICY DEVELOPMENT, PLANNING AND RESOURCE ALLOCATION

As mention in the introduction, the policy of overall development, health development and human resources policy development should be linked and interacted in achieving the everall development goals. However, the links and interaction within components and between these development are not as easy as the above statements. There are several factors which influence these links and interaction, i.e.:

1. Change in Political System, which can be differentiated into several eras, i.e.: Era of Old Order (before 1966), Era of New Order (1966-May 1998), and Era of Reformation Order (after May 1998).
2. Political and Administrative Decentralization.
3. Public Sector and Civil Reforms.
4. Macro Economic Trends.
5. Demographic Trends.
6. Epidemiologic Changes, and
7. Socio-cultural Changes.

The last health policy and plan carried out in the end of 1997. This health policy and plan concerns about the next five year health development which is manifested in the "GBHN 1998", the Seventh Five Year Health Development Plan or "REPELITA VII" (1998/1999-2003/2004) and annual health development plan for 1998/1999.

The last policy and strategy for human resource development implemented in the end of 1997. This plan is in conjuction to the Seventh Five Year Health Development Plan or "REPELITA VII". However, the real comprehensive health manpower plan was carried out in early of 1980s. After this comprehensive plan, efforts to the next health manpower plan was conducted by development of counting method toward the need of health manpower in the health institution based on the ISN or Indicator of Staff Need in 1985. This method had been discussed several times, but its application faced with several problems such as the difficulties of replacing the health personnel to the places which were appropiate and really needed. This replacement faced several important aspects such as housing, budget and others. In 1991, with the country development budget, the modification of ISN method was implemented in 5 provinces (West Nusatenggara, East Kalimantan, East Java, West Sumatera and South Sulawesi provinces), however, the results showed that the formula of ISN methods was not appropriate enough.

In World Bank Health Project V (HP-V) which is a project concerning Professional Health Manpower Development, the Application of Health Manpower List or "DSP" with full authority of Province and District Health Offices in producing and placement of health manpower will be tested. The reward and insentive system will also be carried out along this trial.

The total review of national health manpower policy has not been performed yet, however some small scale review for policy adjustment has been carried out. For example: the change of health manpower policy to "zero personnel growth" resulted a policy adjustment with launching of the "contract of medical doctor and contract of midwife" in fulfiling the national goals of reducing the IMR and MMR to the certain levels of achievements.

The process of formulating the current human resource development policy plan has been carried out based on the general planning process mentioned before. This process has been coordinated by the Bureau of Planning MOH. At least there are eleven institutional units in relation to the health manpower in MOH. They are: 1. Bureau of Plannung; 2. Bureau of Personnel; 3. Center for Health Manpower Education and Training; 4. Center of National Health Education; 5. Division of Personnel in Each Directorate General/NIHRD (5 division); 6. Center for Health Data; 7. Inspectorate of Personnel. Each unit at the MOH carries out planning and implementation based on its own responsibilities. The Bureau of Planning that should coordinate all of the planning has not been able to develop a comprehensive and integrated planning. This bureau has only been able to compile all of those planning proposed by each institution and negotiate budget needed with the MOP and MOF. For example, planning and authority to develop health education units/schools under the MOH is under the responsibility of Center of National Health Education. Bureau of Planning does not do a plan of how many and what kind of health education units/ schools are needed as well as how many each school should produce health manpowers in every year.

The above discussion is limited only by the health manpower within and between units in the MOH. Outside of MOH, there are universities which produce Medical Doctor (GP, Specialists and Superspecialists), Dentists, Pharmacist, Master of Public Health, Master of Nurse etc. This will make all of the planning, implementation, monitoring, and evaluation procedures of health manpower become more complicated. In addition, universities can be public and private universities, and both of them are under Ministry of Education (MOE). Moreover, the implementation of health services and health development is carried out by both public and private sectors. There are a high demand and need for the growing of private sectors in the health field, it is not only hospitals, health centers, and clinics, some promotive and preventive private foundations are established. These demands and needs resulted more complicated planning, implementation, monitoring and evaluation of health manpowers as well as coordination capability of MOH.

In the document of "GBHN" and other there is an explicit or implicit links between policy for human resource development and overall national helath policy in terms of contents and process. However, mechanism and structure of organization in MOH which is responsible to health manpower development is not appropriate enough. Therefore, as mentioned before, health manpower development has still been handle in a fragmented way. Each unit in MOH has carried out its own planning and

implementation with very superficial coordination by the Bureau of Planning.

The top priorities for human resource in health development are not stated explisitely or implisitely. From the document of "REPELITA VII", the top priorities of human resourse development are:

1. Equity and quality distribution of every kind of health manpower in achieving the goal of health development, particulary in reducing the IMR and MMR.
2. Produce health manpower with high capability in health/medical technology in order to be able to compete with foreign health manpower in expecting globalization era in the next decade.
3. Development of health manpower system which can optimize the efficiency and effectiveness of the use of available health manpower.
4. Technical, managerial and mental development of the existing health manpower.
5. Development of law, procedure and standard competencies and ethics of health manpower in various field of responsibilities to empowering.

Representatives from the eleven institutions mentioned before plus representatives from National Institute of Health Research and Development, various public and private universities, professional organizations, consorium of health sciences (with Bureau of Planning as the coordinator) are those the most responsible persons for priority setting and strategic planning of human resourses in health.

The sources of expenditure for education of HRH within MOH can be divided into sources from Government, Foreign Aids (**Grant** and **Loan**) as well as private or self budgeted. The expenditure is available in fiscal year expenditure. For this paper, fiscal years used by us are limited only at fiscal year 1984/1985, 1989/1990 and 1994/1995. The expenditure for education of HRH includes:

1. Expenditure for Center for Education and Training of the HRH within MOH (no formal degree).
2. Expenditure for Center for National Education of HRH within MOH (bachelor degree, master and doctoral degrees, excludes degree for medical doctor, pharmacist and dentis).

The comparison of expenditure for education among the health manpower in Indonesia can be seen in the table 1.

INSTITUTIONAL REFORMS, ORGANIZATIONAL STRUCTURES AND REGULATION

As mentioned in the previous discussion, there are some inconsistencies of existing organizational structures and agreed human resource

Table 1. Comparative Expenditure for Health Manpower Education in Indonesia 1984/1985, 1989/1990 and 1994/1995 in Million Rupiah

Fiscal Year and Subject	Goverment Expenditure	Foreign Assistant	Private/Self Budgeted	Total Expenditure
1984/1985				
■ Education	32,676 (6%)	– (0%)	26,332 (2%)	59,008 (3.1%)
■ Total Health Exp	544,600 (100%)	30,300 (100%)	1,316,600 (100%)	1,1891,500 (100%)
1989/1990				
■ Education	33,131.3 (3.9%)	38,572.4 (23.1%)	30,630 (1.4%)	102,334.6 (3.2%)
■ Total Health Exp.	852,723.4 (100%)	167,271.2 (100%)	2,201,669.1 (100%)	3,221,663.7 (100%)
1994/1995				
■ Education	119,762.8 (5.4%)	41,054.3 (11.0%)	44,534.2 (1.0%)	205,351.3 (2,9%)
■ Total Health Exp.	2,226,308.9 (100%)	373,271 (100%)	4,448,613.8 (100%)	7,088,755.9 (100%)

development policies and strategies especially in the function of Bureau of Planning to coordinate at least the comprehensive and integrated planning of the whole components related to HRH. However, substantially there are efforts to fit the organizational structures and agreed human resource development policies and strategies. For example, the MOH has launched the placement of mid-wife at least one mid-wife in each village in Indonesia (roughly 66,000 villages) since 1992. This policy is in regard to fulfil the program policy to reduce MMR from 450/100,000 live birth (1992) to 225/100,000 live birth by the year of 2000. Recently, about 95% of the villages in Indonesia has had already at least one mid-wife. In order to provide more incentive to the mid-wife, the MOH has developed a contract mid-wife program with more payment if she works in the remote or very remote areas. Her salary is sent directly to her, and not necessarily has to go through bureaucracy channel. All of equipments related to normal delivery and family planning programs have been provided by the MOH. The village MCH clinic has been built by the local government and the local community by using the mutual collaboration principle. This is quite different with the recruitment of mid-wife before 1992, in which she should be the government official first in order to be placed in the Health Center at the sub-

district level and not at the village level. This HRH contract policy is also used for new Medical Doctor (GP) and dentist.

Other reforms which are declared by the Ministry of Planning and Head, National Planning Bureau are as follows:

1. Decentralization of the management system of placement and tour of duty HRH to the local government.
2. Decentralization of the implementation of training of HRH to the local government.
3. Rotation, tour of duty and tour of area for HRH, perticularly for echelon II and III at the national and local level
4. Improvement of the planned HRH quality through formal education either in country or abroad.
5. Faster the fulfilment of specialist mecical doctor at the District Hospital
6. Changing the selection of hospital director based on "merit system".
7. Recruitment of HRH by the hospital director based on the local health services needs.
8. Faster the fulfilment of faculties at the School of Medicine, either public or private.
9. Simplified the recruitment and placement procedures of specialist medical doctors.
10. Appropriate planned of how to manage the contract doctors after they have fulfilled their contracts.

Instituitional reforms in relation to human resources for health at the national level has been on going. However, at the village level, the MOH has developed a community health clinic in every village as mentioned above. This clinic belong to the community and/or the local village council. This clinic has been headed by a midwife who is no longer a government official rather than a contract mid-wife.

Relationship between the central ministry with decentralized levels of institutions is much better during the last decade. Some projects are already given to the province or district level. However, unfortunately, for HRH is still under central MOH control. For example, if a medical doctor is graduated from the Medical School, he/she has to report to the local province health office and he/she will get a letter from the local health province office to MOH (Bureau of Personnel), then he/she has to choose what alternative provinces he/she want to be placed. He/she has to fill in an application and submitted to the MOH. Due to plenty of them are graduated at once, the MOH will collect all of the application and then the Committee of Health Personnel (consist of various interprograms within the MOH and related sector) will decide based on his/her request, province available or needed and some other criteria. He/she has to wait until he/she get a letter from MOH that he/she is accepted and by the decision of the Commiittee he/she will be place in a certain provinve (it can be within his/her sellection or it can be different). Therefore, he/she has to go to the province health office decided by the Committee and he/she has to report to

the local officer and the local office will send him/her to the district which need a medical doctor. This procedure will be similar when he/she is at the District level.

Roles of private sectors in health and the changes of public policies toward private sector financing and provision is getting significantly better. Due to the public private mix reforms which launched by the MOH a few year ago, there are a lot of privatization in the public hospital and health center. There are also privatization of HRH through the policy of medical doctor, mid-wife, dentist and other HRH contract, and not necesarily as government officials as happened before 1992.

Share between public and private health expenditure is starting since the early of 1990s. However, the private health expenditure is much higher as compare to the public expenditure especially for curative activities. About 70% of health expenditure in Indonesia in 1995 was provided by private sectors and out of pocket, and its mostly was used for curative services, while 30% of health expenditure was supported by the public sector with mostly was used for promotive and preventive programs.

Province Health Office (under the Governoor) and Province Representative Office of MOH (under the MOH) as well as District Health Office (under the Didtrict Administrator) and District should be immediately integrated at each level, so that, there is only one Health Office at each level. Application of hospital autonomy, health center autonomy and decentralization of most of health management to all district in Indonesia should be started in August 1998.

FINANCIAL FLOWS

The flow of funds in supporting the implemantation of priorities for human resource development as set out in policies, plans and budget comes from public sector either routine or development budget in the national level. The MOF disburses all of the agreed budget to each department usually based on the request of each department, mostly the department asks for about 25% as seed money for threemonthly activities. Depend on type of programs, the financial flow is distributed to the province and district levels, for example the CDC programs decentralized all of its budget diretly to district level, while HRH salaries, drugs and other health services are usually channeling through province health offices.

Recent reforms in financial management system and payment procedures for health personnel have been launched by MOH and MOF. For example, the contract medical doctors and midwives obtain their monthly salaries directly through their own bank accounts. The very recent reform concerns with the Social Safety Net Project. This project attemps to maintain or if it is possible to increase the health status of mother, baby and children

among the poor in Indonesia which are recently suffering from the monetary, economic and political crisis. All budget related to this programs will be sent directly to the subdistrict and village levels, as well as all budget concerning to the HRH salaries will be sent directly to their own bank accounts and disregard they are contract HRH or government officials.

Banking and accounting system of externally funded projects have been put in separated way, however the management structure and system is not separated. This is due to the application at the field level of each project is inseparable with the routine program.

The recent changes in financial flows is projected to affect the effectiveness of health service delivery. With the straight forward financial flow and salary, hopefully the program does not have anymore problem regarding to the budget. The performances of HRH will be expected to be better. However, monitoring and supervision should be carried out seriously in maintaining the project accountability.

Conditional grants/ earmarking funds (from donors, local government) for human resource development activities are usually related to the activities at the province and district levels. It is not easy to get candidates to be sent for higher degree of education and it is not easy to obtain to develop programs related to improve the performances of HRH which is appropriate enough.

The roles of donors and technical assistance in priority setting and strategic planning for HRH are quite limited. Most of technical consultants and expertise are related to the projects which are funded by each donor agency. There is no special consultant for HRH development at the MOH.

PERFORMANCE MONITORING

The general monitoring of the progress in HRH policy development and implementation has been developed by the Center of Health Data. However, until nowadays even the tools are still uncertained, and the system information is still also fragmented.

The current approaches or recent developments regarding the definition and monitoring of health personnel performance are also still uncertained. Most of HRH performances are monitored and evaluated by using a survey, small scale study or evaluation made by each division related to the HRH. For example, Center of Education and Training of HRH has yearly evaluated its own performance. Bureau of Personnel does the same thing as well as other related divisions.

The existing information system is not capable in providing key performance indicators for health personnel at different level of the system. Each division has its own reporting and recording systems. These systems are separated each others.

The roles of donors and technical assistance in monitoring and eveluating the HRH performance are very relative. Some donors concern about it, however most donors do not really concern about HRH. Several evaluations have been made by some of donor agencies in HRH as part of their overall projects.

TECHNICAL ASSISTANCE AND EXPERTISE

The percentage of technical assistance of the total health budget, including external aid is about 30%, however, most of them are taken from original countries of donors such as USAID usually uses American consultants.

Acess expertise of health sector from other relevant countries and situations is rather difficult, except expertise from WHO Regional Office. This expertise is also difficult to be proposed.

Technical assistance defined, development of terms of referrence agreed, and technical assistance chosen and assessed by both parties, Indonesia and donors.

There is a coordination meeting between the suppliers and technical assistance and expertise in avoiding duplication and confusion at the ministrial level and usually it is coordinated by WHO. This is needed by the MOH, because some projects are similar and on line with WHO policies. There is also a forum of coordination among the UN donor agancies.

OTHER IMPORTANT INFORMATIONS

Due to several divisions responsible to the HRH, it is difficult to generate all of the WHO questions. Therefore, the followings are some additional informations resulted from our discussion with several key persons in the divisions which are responsible to the HRH. The divisions are the Center for Education and Training of HRH, and the Center for National Education for HRH.

A. *Center for Education and Training of HRH (PUSDIKLAT)*

The functions of this center are to train MOH staffs and to train community regarding the MOH programs. These duties include to organize the health training among health providers and community health education carried out by the GOI and to provide accreditations to those trainings and educations.

Methods used for training and education are classical, long distance and on the job training Training and education can be divided into structural (for example compulsory administrative training for echelon IV and III health personnel), functional (i.e.: administrative training for medical doctors, dentists, researchers etc.) and technical (for example IUD insertion for medical doctor in hospital and health center, etc.).

Planning should be based on the need analysis of health training and education which is coordinated by the Bureau of Planning, however, as a matter of fact, this division is still carried out its own planning. This plan of the center is not program oriented but it is still budget oriented, therefore targets of 275,000 staffs being trained and educated are not achieved, it is only 48,000 personnel have been trained and educated. About 27.9% of MOH training and education has been managed by this center, while the remain budget are managed by other major unit within the MOH. During this crisis period, 20% of the center budget has been cut by the MOH.

Coordination with the Bureau of Personnel is only in the training of *compulsory training for echelon III and IV*, there is no coordination in the technical training yet. While most of technical training have still been carried out by each major units within MOH. In these last few years, some of major unit training have given some of technical training to the center for example training related to vector borned diseases, urban health development, rural health development and environmental health.

There have been 272 trainers which are distributed based on the local needs to 27 provinces throughout Indonesia. They should make training and education plan based on the assessment they have to carried out in each province.

AusAID assisstance has been started from 1996, In which 86 national health providers and 60 provincial health providers have been trained in Australia. In country training assisted by AUSAID are 3 classes of 18 midwives, 3 classes of providers who responsible for drug storage at the district level and 3 classes for hospital management. Long distance courses for medical technologies are carried out for certain provices as follows.

1. First Year (1995): 2 provinces.
2. Second Year (1996): 12 provinces.
3. Third Year (1997): 13 provinces.
4. Fourth Year (1998): 27 provinces.

There are two consultants for this long distance courses (one consultant from England for implementation and another consultant from Australia for evaluation).

Other foreign assistance in training and education of health providers in MOH are as follows:

1. HP4 Project (World Bank Loan): training and education of quality *assurance (5 provinces)*.
2. ADB Project: training and education of regerral system (5 provinces).
3. CHN-III Project (World Bank Loan): training and education of *methodology of training (5 provinces)*.
4. HP5 Project (World Bank Loan): training and education in decentralization of health services.
5. WHO Project (INOWHO 104): taining and education for improving technical skills of medical doctor, curriculum development of training and education, development of media for

training and education, and short term fellowship.

B. *Center for National Education for HRH (PUSDIKNAKES)*

The function of this center is merely to develop health providers in getting better degree in order to carry out professionaly their jobs to achieve the MOH goals.

According to some key persons in this center, the planning process is carried out by its own center with bottom up principles. The Province Health Administrator should develop a province specific health manpower development, and then he/she has to send yearly a proposal to the Center for National Education for HRH. The proposals are then used as the major input for the center natinal plan in HRH development. This plan actually should be carried out by the Bureau of Planning, however, it is now still inadequate.

There is about 30% of HRH produced by this center, the remain percentage of HRH is produced by private organization, universities, Ministry of Defence and local governments. Control of educational quality carried out by these remains institutions are carried out by the center. The control system is implemented by using accreditation system.

This center recommends Minister of Health in providing an operational permit for educational institutions which produce bachelor degrees. While operational permits for schools which produced master degree, the center gives recommendations to the Ministe od Education. There is a mutual undertanding agreement between MOH and MOE related to these operational permits.

Foreign aids are used for: rahabilitation of health education institution building, procurement of education equipments, fellowship and books.

Some foreign assistance to this center are as follows:

1. HP5 project of sister school in Central Java, South Kalimantan and South Sulawesi in terms of nursing education (with Australia) and midwife education (with New Zaeland).
2. ADB project for precurement of educational facilities.
3. CHN III for nursing and nutrition education (longterm fellowship).
4. USAID for consultants of curriculum and module of education development.
5. WHO Project for HRH development, strategy and module development.

DAFTAR PUSTAKA

Bachroen, Cholis. 1997. *The Usage of Working Time and Task Variation among Health Workers in the Health Centers in Indonesia: Case Study in Three Provinces.* Buletin Penelitian Sistem Kesehatan. Vol. 1, No. 2, Desember 1997: 1-18.

Bina Pustaka Tama. 1993. *Ketetapan-Ketetapan MPR Republik Indonesia 1993 termasuk GBHN Republik Indonesia 1993-1998.* Jakarta

Casio, Wayne F. 1989. *Managing Human Resources: Productivity, Quality of Work Life, Profits.* 2nd Ed. Singapore: McGraw Hill, Inc.

Departemen Kesehatan RI. 1984. *Sistem Kesehatan Nasional.* Jakarta.

Departemen Penerangan RI. 1989. *Rencana Pembangunan Lima Tahun Kelima 1989/1990-1993/1994.* Jakarta.

Fulop, Tamas and Milton I Roemer. 1987. *Reviewing Health Manpower Development: A Method of Improving National Health System.* Geneva: World Health Organization.

Lawler III, Edward E, David A Nadler and Cortlandt Cammann. 1980. *Organizational Assessment: Perspectiveson the Measurement of Organizational Behavior and the Quality of Work Life.* New York: John Wiley & Sons, Inc.

Steers, Richard M and Lyman W Porter. 1991. *Motivation and Work Behavior.* Singapore: McGraw-Hill, Inc.

Soemantri S, Cholis Bachroen and Kemal N Siregar. 1996. *Studi Awal Pendayagunaan Dokter PTT.* Jakarta: Badan Penelitian dan Pengembangan Kesehatan, Departemen Kesehatan RI.